STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	295044	A. BUILDING _____ B. WING _____	04/13/2007

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HEARTHSTONE OF NORTHERN NEVADA	1950 BARING BLVD SPARKS, NV 89434

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 000	INITIAL COMMENTS This statement of deficiencies was generated as the result of an annual Medicare Re-Certification Survey conducted at your facility 4/9/07 through 4/13/07. The findings and conclusions of any investigation of the Health Division shall not be construed as prohibiting any criminal or civil investigations, actions or other claims for relief that may be available to any party under applicable federal, state, or local laws. The census was 122 residents. The sample size was 25 residents. The following three complaints were investigated during the survey: Complaint #NV00014281 was a facility reported incident of possible staff abuse of a resident. The abuse was unsubstantiated. Deficiencies unrelated to abuse were cited at F 257, F 315, and F 319. Complaint #NV00014391 was facility reported fall with injury. The incident was substantiated. No deficiencies were cited based on the actions by the facility. Complaint #NV00014521 was facility reported fall with injury. The incident was substantiated and a deficiency was cited at F 323.	F 000	**F00** **This plan of correction is prepared And executed because it is required by The provisions of the state and federal regulations and not because Hearthstone agrees with the allegations and citations listed on this statement of deficiencies. Hearthstone maintains that the alleged deficiencies do not individually or collectively, jeopardize the health and safety of the residents, nor are they of such character as to limit our capacity to render adequate care as prescribed by regulation. This plan of correction shall operate as Hearthstone's credible allegation of compliance.** **By submitting this plan of correction, Hearthstone does not admit to the accuracy of the deficiencies. This plan of correction is not meant to establish any standard of care, contract, obligation, or position, and Hearthstone reserves all rights to raise all possible contentions and defenses in any civil or criminal claim, action or proceeding.**	
F 157 SS=D	483.10(b)(11) NOTIFICATION OF CHANGES A facility must immediately inform the resident; consult with the resident's physician; and if known, notify the resident's legal representative or an interested family member when there is an accident involving the resident which results in injury and has the potential for requiring physician	F 157		

RECEIVED
MAY 04 2007
BUREAU OF LICENSURE AND CERTIFICATION
CARSON CITY, NEVADA

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

Molly Larson — Administrator — 5/3/07

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	295044	A. BUILDING _____ B. WING _____	04/13/2007

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HEARTHSTONE OF NORTHERN NEVADA	1950 BARING BLVD SPARKS, NV 89434

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 157	Continued From page 1 intervention; a significant change in the resident's physical, mental, or psychosocial status (i.e., a deterioration in health, mental, or psychosocial status in either life threatening conditions or clinical complications); a need to alter treatment significantly (i.e., a need to discontinue an existing form of treatment due to adverse consequences, or to commence a new form of treatment); or a decision to transfer or discharge the resident from the facility as specified in §483.12(a). The facility must also promptly notify the resident and, if known, the resident's legal representative or interested family member when there is a change in room or roommate assignment as specified in §483.15(e)(2); or a change in resident rights under Federal or State law or regulations as specified in paragraph (b)(1) of this section. The facility must record and periodically update the address and phone number of the resident's legal representative or interested family member. This REQUIREMENT is not met as evidenced by: Based on record review and staff interview, it was determined that the facility failed to notify a resident's legal representative of a fall in accordance with the facility's policy and procedure for 1 of 25 residents. (Resident #20) Findings include: Resident #20: The resident was admitted to the facility on 3/16/07 with diagnoses including end stage renal disease, esophageal reflux,	F 157	**F 157** **Resident # 20's family have been notified.** **Residents residing in the facility have the potential to be affected by this practice.** **All resident families/legal representative/physician will be notified of any accident/occurrence in a timely fashion.** **Incident report will be reviewed by the DON/ADON or designee. chart will be reviewed for proper notification ..** **Staff will be re-in serviced on policy of timely notification of family/legal representative in the event of an accident or other occurrence.** **Monitoring will be completed in the Quality of Care meeting weekly x 90 days and randomly thereafter.** **Results will be reported to the PI committee.**	5-19-07

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	295044	A. BUILDING _____ B. WING _____	04/13/2007

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HEARTHSTONE OF NORTHERN NEVADA	1950 BARING BLVD SPARKS, NV 89434

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 157	Continued From page 2 congestive heart failure, dementia, and blindness. Record review on 4/11/07 revealed that the resident had intermittent confusion. His responsible party was listed as his power of attorney. During record review, Resident #20 was noted to have fallen on 4/9/07. However, no documentation that the resident's legal representative had been notified of the fall was found in the residents medical record. On 4/11/07 at 11:00 AM Employee #17 was interviewed. She stated that the resident's legal representative should have been notified. She also stated that it was the responsibility of the nurse caring for the resident to contact the resident's legal representative, and to then document it in the resident's medical record. On 4/11/07 at 11:15 AM Employee #12 was interviewed. She stated that the facility's policy read that "in the event of a fall, the resident's family, or legal representative will be notified." She was unable to find any evidence that the Resident #20's legal representative had been notified in the resident's medical record. Review of the facility's "Fall Management Program" revealed that the facility's policy required that the resident, family, or legal representative be notified of a fall.	F 157		
F 225 SS=D	483.13(c)(1)(ii)-(iii), (c)(2) - (4) STAFF TREATMENT OF RESIDENTS The facility must not employ individuals who have been found guilty of abusing, neglecting, or mistreating residents by a court of law; or have had a finding entered into the State nurse aide	F 225		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	295044	A. BUILDING _____ B. WING _____	04/13/2007

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HEARTHSTONE OF NORTHERN NEVADA	1950 BARING BLVD SPARKS, NV 89434

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 225	Continued From page 3 registry concerning abuse, neglect, mistreatment of residents or misappropriation of their property; and report any knowledge it has of actions by a court of law against an employee, which would indicate unfitness for service as a nurse aide or other facility staff to the State nurse aide registry or licensing authorities. The facility must ensure that all alleged violations involving mistreatment, neglect, or abuse, including injuries of unknown source and misappropriation of resident property are reported immediately to the administrator of the facility and to other officials in accordance with State law through established procedures (including to the State survey and certification agency). The facility must have evidence that all alleged violations are thoroughly investigated, and must prevent further potential abuse while the investigation is in progress. The results of all investigations must be reported to the administrator or his designated representative and to other officials in accordance with State law (including to the State survey and certification agency) within 5 working days of the incident, and if the alleged violation is verified appropriate corrective action must be taken. This REQUIREMENT is not met as evidenced by: Based on interview and record reviews it was determined the facility failed to ensure that staff reported an allegation of verbal abuse in order to conduct an investigation and determine if corrective action was necessary for 1 of 25	F 225	**F225** **F225** **An investigation was initiated related to resident #19 and C.N.A. #1. C.N.A. # 1 is no longer employed by Hearthstone. C.N.A. #2 has had corrective action taken as necessary.** **Residents residing in the facility have the potential for being affected by the deficient practice.** **Staff will be re-in serviced on policy of reporting abuse by Director of Education/DON/ADON/Abuse Coordinator.** **Mandatory all staff meeting on abuse reporting and abuse coordinator information will be held every 6 months.** **DON/ADON Director of Education will monitor and report results to the PI Committee.**	5-19-07

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	295044	A. BUILDING _____ B. WING _____	04/13/2007

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HEARTHSTONE OF NORTHERN NEVADA	1950 BARING BLVD SPARKS, NV 89434

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 225	Continued From page 4 residents. (Resident #19) Findings include: Resident #19: The resident was admitted to the facility on 10/5/06, with diagnoses that included congestive heart failure, edema, malaise and fatigue, atrial fibrillation, leg varicosity with ulcer, open knee wound, benign hypertension and chronic airway obstruction. A review of the most recent MDS dated 4/4/07, social services evaluations and nursing notes revealed that Resident #19 was alert and oriented to time, person, place and situations. A review of the physicians orders revealed that the resident was free of mental illness and was not receiving any psychotropic medications. Interviews with the administrator and nursing staff on 4/12/07, revealed the resident was not displaying any behavioral symptoms and that he was a good conversationalist. During an interview with Resident #19 on 4/12/07, the resident stated that CNA #1 called him a "Pain in the ass" on 4/06/07. The resident stated that on another occasion the same CNA was swearing around him when assisting with cares. The resident also revealed during interview on 4/12/07, that he informed CNA #2 of the allegation on the day it occurred. The resident stated that CNA #2 suggested that Resident #19, "should report this to the nurse in charge." A review of the facility's incident reports generated by the facility for purposes of reporting to BLC and DAS, failed to reveal evidence of an investigation of the allegation of verbal abuse that was reported to CNA #2 by Resident #19.	F 225		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	295044	A. BUILDING _____ B. WING _____	04/13/2007

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HEARTHSTONE OF NORTHERN NEVADA	1950 BARING BLVD SPARKS, NV 89434

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 246 SS=E	483.15(e)(1) ACCOMODATION OF NEEDS A resident has the right to reside and receive services in the facility with reasonable accommodations of individual needs and preferences, except when the health or safety of the individual or other residents would be endangered. This REQUIREMENT is not met as evidenced by: Based on interview, policy review, and observation it was determined that the facility failed to meet the food preferences of 4 of 7 residents who attended the group interview. Findings include: An inspection of the kitchen on 4/9/07 revealed that the facility purchased pasteurized (in the shell) eggs. Interview with the food service manager on 4/11/07 revealed that it was corporate policy that only pasteurized (in the shell) eggs would be purchased. When asked why hard fried eggs were listed on the breakfast menu, the food service manager indicated that corporate policy dictated that soft cooked eggs could not be served to the residents. During the group interview conducted on 4/10/07 at 1:30 PM, 4 of 7 residents indicated they preferred soft cooked eggs, but the facility did not serve them. A review of the corporate policy revealed that all eggs, including pasteurized eggs, were to be cooked until the yolk was set, and that eggs were to be considered a hazardous food product. However, the policy indicated that pasteurized	F 246	**F 246** **Specific residents were not cited for this issue.** **Residents residing in the facility can be affected by this practice.** **Dietary Manager and Dietician were re educated on the accommodation of individual needs and preferences, except when the health or safety of other residents or individuals would be endangered.** **Dietary Manager or designee will monitor patient satisfaction through the resident council meeting monthly x 3, randomly thereafter. Results will be reported to the PI Committee.**	5-19-07

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	295044	A. BUILDING _____ B. WING _____	04/13/2007

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HEARTHSTONE OF NORTHERN NEVADA	1950 BARING BLVD SPARKS, NV 89434

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 246	Continued From page 6 eggs were salmonella free.	F 246		
F 257 SS=D	483.15(h)(6) ENVIRONMENT- TEMPERATURE The facility must provide comfortable and safe temperature levels. Facilities initially certified after October 1, 1990 must maintain a temperature range of 71 - 81° F This REQUIREMENT is not met as evidenced by: Based on interview and observation it was determined the facility failed to ensure comfortable shower room temperatures for 2 of 25 residents in Hallway A. (Residents #10 and #5) Findings include: Resident #10: The resident was admitted to the facility on 6/30/07, with diagnoses that included sepsis, hypothyroidism, thoracic aortic aneurysm and retention of urine. A review of Resident #10's quarterly MDS assessment dated on 3/21/07, revealed there was no indication of cognitive impairment and that she was able to make herself understood. Record review revealed there was no indication of behavioral symptoms or mood disorders. On 4/11/07, an interview with Resident #10 revealed that the "shower room was cold" after staff assisted the resident in the shower. The resident said that the staff would provide a blanket, but that the blanket was cold.	F 257	**F257** **The Maintenance Department has run a new heat line to the A Wing Shower.** **Residents residing in the facility have the potential to be affected by this deficient practice.** **The Maintenance Department or designee will monitor heat levels to assure the temperature stays between 71 and 81 Fahrenheit.** **Administrator or designee will monitor through resident council feedback and customer satisfaction surveys. Results will be reported to the PI Committee.**	5-19-07

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	295044	A. BUILDING _____ B. WING _____	04/13/2007

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HEARTHSTONE OF NORTHERN NEVADA	1950 BARING BLVD SPARKS, NV 89434

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 257	Continued From page 7 Resident #5: The resident was admitted to the facility on 6/9/05 with diagnoses that included cardiac dysrhythmias, pacemaker implantation, syncope and collapse, hypothyroidism, myalgia, and myositis, diverticulosis of the colon, history of brain cancer, chronic obstructive airway disease, and fractured head of the femur (prior to admission). Review of the record revealed that the resident refused to shower after episodes of incontinence. In an interview on 4/11/07, Resident #5 stated that one of the reasons that she did not like to shower was because the room was so cold and that it took so long to get warm again afterwards. An observation of the shower room on Hallway A revealed that the floor and walls were covered in ceramic tile. No source of heat was found other that an air duct in the ceiling.	F 257		
F 279 SS=D	483.20(d), 483.20(k)(1) COMPREHENSIVE CARE PLANS A facility must use the results of the assessment to develop, review and revise the resident's comprehensive plan of care. The facility must develop a comprehensive care plan for each resident that includes measurable objectives and timetables to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment. The care plan must describe the services that are to be furnished to attain or maintain the resident's	F 279		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	295044	A. BUILDING _____ B. WING _____	04/13/2007

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HEARTHSTONE OF NORTHERN NEVADA	1950 BARING BLVD SPARKS, NV 89434

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 279	Continued From page 8 highest practicable physical, mental, and psychosocial well-being as required under §483.25; and any services that would otherwise be required under §483.25 but are not provided due to the resident's exercise of rights under §483.10, including the right to refuse treatment under §483.10(b)(4). This REQUIREMENT is not met as evidenced by: Based on record review and interviews, it was determined that the facility failed to ensure that resident care plans included evidence of coordination of care with the hospice agency for 3 of 25 residents. (Residents #18, #4, and #6) Findings include: Resident #18: The resident was admitted to the facility 1/30/07 and readmitted on 2/28/07 with diagnoses including duodenal ulcer, anemia, vascular dementia, gastrointestinal bleed, diabetes, congestive heart failure, atrial fibrillation, and renal insufficiency. Resident #18 was placed on hospice care on 3/29/07. Nurses notes of 4/2/07 indicated that the hospice nurse reviewed the hospice care plan with the facility staff. Review of the medical chart revealed that the facility care plan was initiated on 3/13/07 and had not been revised or edited to indicate that hospice services had begun on 3/29/07. There was no evidence of the hospice care plan in the record. An interview with the assistant director of nurses (ADON) revealed that the hospice care plan was not in the facility. The hospice care plan was	F 279	**F279** **Resident # 6 and 18 no longer reside in the facility. Resident #4's care plans include evidence of coordination of care with hospice agency.** **Residents residing in the facility receiving hospice services have the potential to be affected by this practice.** **Hospice will be in serviced by facility on necessity of having hospice and facility development of care plans together to reflect the care residents are receiving.** **This will be monitored through our Quality of Care Meetings. DON/ADON or designee will monitor and report to the PI Committee.**	5-19-07

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	295044	A. BUILDING _____ B. WING _____	04/13/2007

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HEARTHSTONE OF NORTHERN NEVADA	1950 BARING BLVD SPARKS, NV 89434

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 279	Continued From page 9 obtained by the hospice agency on 4/12/07. The ADON acknowledged that all facility staff caring for the resident did not have access to the hospice care plan since its initiation, nor was the facility care plan updated since 3/13/07. Resident #4: The resident was admitted to the facility on 3/24/06 with the diagnoses that included metastatic cancer and depression. The resident was on hospice. Review of the most recent Care Plan Conference notes dated 3/12/07, stated that the hospice personnel attended the meeting for Resident #4. Review of the facility care plan dated 3/10/07 contained no reference to care provided to the resident by the contracted hospice service. There was no evidence of coordination of care between the facility staff and the hospice staff documented in the care plan. On 4/9/07 at 12:30 PM an interview was conducted with Employee #14 and revealed that the hospice agency and the facility had their own care plans. She did not know where the hospice care plan was located. On 4/10/07 at 9:00 AM, Employee #18 stated that there was no hospice care plan in the chart and there was no hospice component in the facility care plan. Resident #6: Review of the record revealed that the resident was admitted to the facility on 3/14/07 with diagnoses including fractured radius, vascular dementia, hypothyroidism, contractures, malaise, and dysphagia. Record review revealed	F 279		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	295044	A. BUILDING _____ B. WING _____	04/13/2007

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HEARTHSTONE OF NORTHERN NEVADA	1950 BARING BLVD SPARKS, NV 89434

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 279	Continued From page 10 that the resident had been admitted to hospice services on 4/10/07. The facility care planned for her decline in functional status on 4/10/07 including a referral to hospice if so ordered by the physician. The hospice nurse was to assess the resident as needed to manage pain and other uncomfortable symptoms. It was noted in the record that the hospice staff came and accepted the resident onto the hospice services and wrote orders on 4/10/07. There were no subsequent changes to the care plan after those orders were written to show how the care of this resident was to be coordinated by the facility staff with the hospice staff to meet needs of the resident. On 4/12/07 at 11:30 AM, an interview with Employee #17 revealed that she was not aware of the hospice plan of care and how it was coordinated with the facility care plan for Resident #6. She was not able to locate the hospice plan of care in the record.	F 279		
F 309 SS=D	483.25 QUALITY OF CARE Each resident must receive and the facility must provide the necessary care and services to attain or maintain the highest practicable physical, mental, and psychosocial well-being, in accordance with the comprehensive assessment and plan of care. This REQUIREMENT is not met as evidenced by: Based on record review and interview it was determined that the facility failed to obtain testing as ordered by the physician for 1 of 25 residents. (Resident #1)	F 309		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	295044	A. BUILDING _____ B. WING _____	04/13/2007

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HEARTHSTONE OF NORTHERN NEVADA	1950 BARING BLVD SPARKS, NV 89434

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 309	Continued From page 11 Findings include: Resident #1: The resident was admitted to the facility on 4/19/05 with diagnoses including chronic obstructive airway disease, bipolar disorder, benign hypertension, osteoporosis, depressive disorder, vascular dementia, hypercholesterolemia. During record review, Resident #1 was noted to have been treated for a right clavicle fracture that was identified through x-ray on 12/2/07. The resident was seen for a follow up appointment on 1/3/07 with the orthopedic physician. At that time, an x-ray of the right clavicle was ordered by the orthopedic physician, to be done "in three weeks." No evidence that the follow up x-ray had been done was found in the residents medical record. On 4/09/07 at 2:15 PM, Employee #14 was interviewed. She stated that she was not sure if the x-ray had been completed, but would call the provider that would have done the x-ray to see if it had been done. She then placed a telephone call to the provider, and was told that the x-ray had not been done. On 4/9/07 at 2:40 PM Employee #12 was interviewed. She stated that the x-ray should have been scheduled by the nurse caring for the resident at the time she returned to the facility following the appointment on 1/3/07. She stated that she did "not know how this was missed."	F 309	**F 309** **Copies of follow-up x-rays has been obtained for resident #1 from orthopedic physician and are in the medical record.** **Residents requiring outside services have the potential to be affected by this practice.** **DON/ADON or designee will randomly review orders for follow up appointments. They will then coordinate with the transportation aide and a copy of the follow up will be put in a binder and a copy in the medical record.** **Quality Care team will monitor follow up appointments and outcomes in Quality of Care weekly for 90 days, then randomly thereafter.** **DON or designee will report results to the PI Committee.**	5-19-07
F 315 SS=D	483.25(d) URINARY INCONTINENCE Based on the resident's comprehensive assessment, the facility must ensure that a resident who enters the facility without an indwelling catheter is not catheterized unless the	F 315		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	295044	A. BUILDING _____ B. WING _____	04/13/2007

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HEARTHSTONE OF NORTHERN NEVADA	1950 BARING BLVD SPARKS, NV 89434

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 315	Continued From page 12 resident's clinical condition demonstrates that catheterization was necessary; and a resident who is incontinent of bladder receives appropriate treatment and services to prevent urinary tract infections and to restore as much normal bladder function as possible. This REQUIREMENT is not met as evidenced by: Based on record review, it was determined that the facility failed to ensure that a resident who was incontinent of bladder was provided with treatment and services based on a comprehensive assessment to restore as much normal bladder function as possible for 1 of 25 residents. (Resident #5) Findings include: Resident #5: The resident was admitted to the facility on 6/9/05 with the diagnoses that included cardiac dysrhythmias, pacemaker implantation, syncope and collapse, hypothyroidism, myalgia, and myositis, diverticulosis of the colon, history of brain cancer, chronic obstructive airway disease, and fractured head of the femur (prior to admission). Review of the admission Minimum Data Set (MDS) dated 6/21/05 revealed that Resident #5 was occasionally incontinent of bladder. The annual MDS of 5/30/06 indicated that the resident was frequently incontinent of bladder. The quarterly MDS of 8/22/06 and the quarterly MDS of 2/6/07 noted that the resident was incontinent of bladder. Review of the care plans for Resident #5,	F 315	**F 315** **B/B program has been initiated to establish TIAN (Toileting in Anticipated Needs) for resident # 5.** **Residents residing in the facility who are incontinent have potential to be affected by this practice.** **Bowel and Bladder program will be reviewed every 30 days for re evaluation and determine adjustments for individual incontinent residents by DON/ADON or designee.** **This will be monitored in Quality of Care weekly meeting x 90 days, then randomly thereafter.** **DON or designee will report results to the PI Committee.**	5-19-07

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	295044	A. BUILDING _____ B. WING _____	04/13/2007

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HEARTHSTONE OF NORTHERN NEVADA	1950 BARING BLVD SPARKS, NV 89434

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 315	Continued From page 13 revealed a care plan dated 6/6/06 that indicated that the resident was frequently incontinent of bladder and required limited assist with toileting. The approaches included: "encourage ____ to verbalize toileting needs; assist as needed with toileting; monitor for episodes for incontinency, document on better tools; and check diaper and pads at least every two hours." On 8/22/06 the approach of "scheduled toileting program" of every three hours under the supervision of the restorative aid program was added. Review of the restorative nursing weekly progress notes for December 2006 revealed that Resident #5 was continent of bladder from 45 to 91 percent of the time. In March of 2007 the notes indicated that the resident was, on average, continent of bladder 30 percent of the time. Review of the bowel and bladder assessment revealed that there was no assessment as to the cause of the resident's incontinence. Review of the record failed to reveal evidence of a urological evaluation, and when asked the assistant director of nurses (ADON) was not able to provide a report.	F 315		
F 319 SS=D	483.25(f)(1) MENTAL AND PSYCHOSOCIAL FUNCTIONING Based on the comprehensive assessment of a resident, the facility must ensure that a resident who displays mental or psychosocial adjustment difficulty receives appropriate treatment and services to correct the assessed problem. This REQUIREMENT is not met as evidenced by: Based on record review and staff interview, it was determined that the facility failed to obtain a	F 319		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	295044	A. BUILDING _____ B. WING _____	04/13/2007

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HEARTHSTONE OF NORTHERN NEVADA	1950 BARING BLVD SPARKS, NV 89434

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 319	Continued From page 14 psychological or psychiatric evaluation for behaviors in accordance with the care plan for 1 of 25 residents. (Resident #5) Findings include: Resident #5: The resident was admitted to the facility on 6/9/05 with the diagnoses that included cardiac dysrhythmias, pacemaker implantation, syncope and collapse, hypothyroidism, myalgia, and myositis, diverticulosis of the colon, history of brain cancer, chronic obstructive airway disease, and fractured head of the femur (prior to admission). Review of the care plans for Resident #5 that were initiated on 6/6/06, revealed that in Problem #5 the resident was angry with staff, refused therapy, and seemed upset about not returning home with her son. Problem #6 identified behaviors by the resident such as throwing soiled briefs and underpads on the floor and got agitated when the staff picked them up. Problem #15 noted that the resident was verbally aggressive with the staff. Problem #16 noted that the resident was depressed, refused activities of daily living, bathing and bed change, had an episode of anger, and refused Prozac. One of the approaches listed in Care Plan #16 was to "perform psychological/ psychiatric consult as needed." Review of the record failed to reveal evidence of tracking of these behaviors in current or thinned records. It was unclear if the care plans had been evaluated or updated with additions or changes in the approaches to the problems since inception other that a date entry each quarter in the goals column. Review of the record revealed documentation that Resident #5 called the police on 3/17/07 to report that the staff	F 319	**F319** **Resident # 5 will have a psychiatric consultation and behavior tracking has been implemented** **Residents with behavior issues have the potential to be affected by this practice.** **Facility has contracted with Nevada Licensed psychiatrist to provide psychiatric evaluations and follow ups as needed.** .. **Social Services or designee will monitor behavior program through Quality of Care weekly x 90 days and randomly thereafter.** **Results will be reported to the PI Committee.**	5-19-07

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	295044	A. BUILDING _____ B. WING _____	04/13/2007

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HEARTHSTONE OF NORTHERN NEVADA	1950 BARING BLVD SPARKS, NV 89434

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 319	Continued From page 15 forced her to shower. Review of the record failed to reveal evidence of a psychological or psychiatric evaluation. An interview with the licensed social worker (Employee #16) on 4/10/07 confirmed that the resident had presented negative behaviors since she came to the facility. When asked about a psychological or psychiatric consult as noted in the care plan, she stated that she was not aware of any community resources or physician who would come to the facility to evaluate the resident. She also did not know of any resources for training of facility staff to work with this resident and others with similar issues.	F 319		
F 323 SS=D	483.25(h)(1) ACCIDENTS The facility must ensure that the resident environment remains as free of accident hazards as is possible. This REQUIREMENT is not met as evidenced by: Based on interview and incident review, it was determined that the facility failed to prevent an accident to 1 of 25 residents. (Resident #25) Findings include: Resident #25: Review of the record revealed an incident on 4/2/07 where the resident was found outside the facility in a wheelchair at 12:20 AM. The resident had a laceration above the right eye that required 12 sutures. The resident had no prior history of wandering and could self propel in her wheelchair. An interview with the administrator revealed that the	F 323	**F 323** **Resident # 25 was seen by a physician and appropriate care give as necessary. Resident has been re evaluated for elopement potential and wander guard has been put in place.** **Residents with impaired cognition have the potential to be affected by this practice.** **Residents with impaired cognition will be re evaluated for elopement potential by Social Services or designee. A code key pad was installed on the inside as well as the outside of the door.** **Maintenance Department or designee will monitor door locks weekly x 90 days and then randomly thereafter. Social Service or designee will monitor elopement assessments through Quality of Care weekly x 90 days, then randomly thereafter.** **Results will be reported to the PI Committee.**	5-19-07

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	295044	A. BUILDING _____ B. WING _____	04/13/2007

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HEARTHSTONE OF NORTHERN NEVADA	1950 BARING BLVD SPARKS, NV 89434

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 323	Continued From page 16 front side entry door did not lock at the time of the incident and was not alarmed. It was believed the resident exited that door. The lock had broken and was broken at the time of the survey last year. The facility relied on closing the interior hallway door to prevent residents from entering the exit corridor. At the time of the incident, the administrator indicated that the hallway door had been left open. The administrator indicated that after the incident the door lock was repaired and the door was alarmed.	F 323		
F 425 SS=E	483.60(a),(b) PHARMACY SERVICES The facility must provide routine and emergency drugs and biologicals to its residents, or obtain them under an agreement described in §483.75(h) of this part. The facility may permit unlicensed personnel to administer drugs if State law permits, but only under the general supervision of a licensed nurse. A facility must provide pharmaceutical services (including procedures that assure the accurate acquiring, receiving, dispensing, and administering of all drugs and biologicals) to meet the needs of each resident. The facility must employ or obtain the services of a licensed pharmacist who provides consultation on all aspects of the provision of pharmacy services in the facillty. This REQUIREMENT is not met as evidenced by: Based on observation and staff interview it was determined that the facility failed to dispose of	F 425		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	295044	A. BUILDING _____ B. WING _____	04/13/2007

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HEARTHSTONE OF NORTHERN NEVADA	1950 BARING BLVD SPARKS, NV 89434

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 425	Continued From page 17 expired medications, failed to secure narcotic medications to prevent access by unauthorized persons, failed to appropriately label medications, and failed to ensure that emergency medications were restocked and available. Findings include: On 4/9/07 at 9:30 AM, an observation of the medication storage room on the "A" wing of the facility revealed the following: 1. Three bottles of Fibersource that expired March 2007; 2. One box of 30 Transigel dressings that expired March 2007; 3. The refrigerator which had an unsecured lock contained vials of Lorazepam; and 4. The top drawer of the medication cart for the 200-300 split assignment, had a partially used vial of Haloperidol 5 mg/1 ml. The date when opened was not indicated on the vial. The vial was not labeled with the resident's name for whom it was prescribed. On 4/9/07 at 10:15 AM the above observations were confirmed with the consulting pharmacist on site. On 4/9/07 at 11:00 AM an observation of the medication storage room on the "B" wing revealed the following: 1. The Emergency drug supply box (E-kit) was not secured or locked allowing access to all narcotics in the box by anyone gaining access to the room. The following narcotics were found in this unlocked box: a. Drawer #1, one vial of Morphine Sulfate	F 425	**F 425** **Expired medications and unmarked medications have been disposed of. Narcotics are being stored with a double system. The Emergency Kit narcotics will be stored under a double locked system and a count sheet has been included. Oral Medications and external medications will not be stored together. Vials will be dated when opened.** **Residents receiving medications in the facility have the potential to be affected by this practice.** **Licensed Nursing Staff will be re educated on medication storage and administration.** **DON or designee will monitor medication room and narcotic count weekly x 90 days, randomly thereafter. Results will be reported to the PI committee.**	5-19-07

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	295044	A. BUILDING _____ B. WING _____	04/13/2007

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HEARTHSTONE OF NORTHERN NEVADA	1950 BARING BLVD SPARKS, NV 89434

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 425	Continued From page 18 10 mg per ml. b. Drawer #2, five vials of Valium 5 mg/1 ml and nine tablets of Ativan 5 mg. c. Drawer #3, one vial of Valium 5 mg/1 ml (10 ml vial), five tablets of Morphine Sulfate Extended Release 15 mg, five Fentanyl patches of 25 micrograms/hour, and four tablets of OxyContin 10 mg. d. Drawer #4, fifteen tablets of Percocet 5/325, eight tablets of Vicodin 5/500, and two bottles of Morphine Sulfate for oral or sublingual administration (30 ml each). e. Review of the sign-out sheet for the E-kit (provided by Employee #12) revealed that there was no stock quantity to indicate how many of each medication should be in the box, and when or if was it replaced. 2. On the stock medication shelving area Calcium Tablets (oral medication) were found next to Bisacodyl suppositories, hydrogen peroxide, and rubbing alcohol (external medications). On 4/9/07 the above observations were confirmed with Employee #14. On 4/9/07 at 2:30 PM the observations were brought to the attention of Employee #12. She indicated that she was not aware of how long the E-kit had been unlocked, the tracking system for monitoring access, the tracking system for the quantity of each narcotic medication, and if and when pharmacy staff restocked it. During the interview, Employee #12 stated that she had not received the monthly pharmacy consultant report of the medication room inspection yet. When it was reviewed after a copy was faxed to her, it mentioned "need to keep refrigerator locked at all	F 425		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	295044	A. BUILDING _____ B. WING _____	04/13/2007

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HEARTHSTONE OF NORTHERN NEVADA	1950 BARING BLVD SPARKS, NV 89434

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 425	Continued From page 19 times," and "unable to find E-kit keys- will followup." Review of the pharmacy policy of the Emergency Medication System provided by Employee #12 as the policy governing the facility's Emergency Medication System, revealed "Omnicare will assure the prompt replacement of used emergency medication stored in Long Term Care Facilities and other Institutions as well as assuring that the these medications are stored properly per acceptable pharmacy practice and state regulations." "A detailed description of your particular emergency medication system(s) process MUST BE INSERTED BELOW." It proceeded to describe what the facility policy and procedure must contain for each medication storage and distribution system to be compliant.	F 425		
F 443 SS=C	483.65(b)(2) PREVENTING SPREAD OF INFECTION The facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease. This REQUIREMENT is not met as evidenced by: Based on review of employee personnel files, it was determined that the facility failed to protect residents from communicable disease by not screening for tuberculosis for 2 of 10 employees. (Employees #5 and #6) Findings include: Employee #5: The employee was a certified nursing assistant with a hire date of 11/28/06 and	F 443		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	295044	A. BUILDING _____ B. WING _____	04/13/2007

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HEARTHSTONE OF NORTHERN NEVADA	1950 BARING BLVD SPARKS, NV 89434

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 443	Continued From page 20 a termination date of 2/22/07. Review of the employee file on 4/11/07 revealed no evidence of preemployment tuberculosis testing. A telephone interview with the Administrator revealed no paperwork related to TB testing could be located on this employee. Employee #6: The employee was a Registered Nurse with a hire date of 12/12/06 and was currently employed by the facility. Review of the employee file on 4/11/07 revealed no evidence of preemployment tuberculosis testing. During a telephone interview with the Administrator it was revealed that no paperwork for tuberculosis testing could be located on this employee.	F 443	**F 443** **F 443** **Employee # 5 no longer works for the facility. Employee # 6 has had the appropriate testing completed.** **Residents residing in the facility have the potential to be affected by this practice.** **Employee files will be audited for appropriate screening. Director of Education has been re educated on pre employment screenings.** **Human Resources or designee will monitor new employees appropriate documentation weekly x 90 and randomly thereafter and report results to the PI Committee.**	5-19-07